Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL MEDICAL CENTER OF EAST TEXAS

Respondent Name
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-98-0296-01

Carrier's Austin Representative Box
Box Number 44

MFDR Date Received
July 1, 1997

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that her doctor . . . told her to come to the emergency room for pain as needed. We would like to request that these charges be reconsidered for payment."

Amount in Dispute: $84.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached is Carrier evidence to support non-payment of incurred Emergency room facility and physician fees."

Response Submitted by: Crawford 1203B Northwest Loop 281, Suite 102, Longview, Texas 75608

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 25, 1996 to December 10, 1996	Outpatient Hospital Services	$84.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following payment exception codes:
   - N – Not Documented
   - C – Negotiated Contract

Findings

1. 28 Texas Administrative Code §133.305(a), effective June 3, 1991, 16 *Texas Register* 2830, requires that "A request for review of medical services and dispute resolution, as described in the Texas Workers' Compensation Act (the Act), §8.26, shall be submitted to the commission at the division of medical review in Austin, no later than one calendar year after the date(s) of service in dispute." The applicability of the one-year filing deadline from the date(s) of service in dispute was confirmed in the court's opinion in Hospitals and Hospital Systems v. Continental Casualty Company, 109 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). Per 28 Texas Administrative Code §102.3(a)(3), effective January 1, 1991, 15 *Texas Register* 6747, "unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day." The request for dispute resolution of services rendered on dates of service May 25, 1996, June 20, 1996, and June 21, 1996 was received by the Division on July 1, 1997. Review of the submitted documentation finds that the request was submitted more than one year after the dates of service. The Division finds that the request for dispute resolution was not submitted timely. The Division concludes that the requestor has not met the requirements of §133.305(a). Therefore service dates May 25, 1996, June 20, 1996, and June 21, 1996 will not be considered in this review. However, the request for dispute resolution of services rendered on July 9, 1996 and September 28, 1996 was submitted in accordance with the timely filing requirements of §133.305(a); therefore, these services will be considered in this review.
2. The insurance carrier denied disputed services with payment exception code C – "Negotiated Contract." No documentation was presented to support a negotiated contract between the parties to this dispute. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
3. This dispute relates to outpatient medical services. The services in dispute were not identified in an established fee guideline during the disputed dates of service; therefore, reimbursement is subject to the provisions of 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) until such period that specific fee guidelines are established by the commission."
4. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
5. Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
   - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	April 4, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.